DOCUMENT RESUME

ED 181 358 CG 014 081

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TITLE Issues in the Therapeutic Use of Meditation.
PUB DATE [78]
NOTE 12p.: Paper presented at the Annual Convention of the American Psychological Association (87th, New York, NY, September 1-5, 1979): Best copy available

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Clinical Psychology: Counselors: Data Collection: Guidelines: *Helping Relationship: *Psychotherapy: *Research Methodology: *Therapists
IDENTIFIERS *Meditation

ABSTRACT

From all indications, meditation is being used more and more by psychotherapists and counselors in their practices. Research has not to date produced empirical guidelines for the therapeutic use of meditation. This report compiles clinical and research data to provide a step toward a systematized approach to the utilization of meditation so as to yield maximal benefit with minimal harm. Observations, findings, and suggestions from the literature are gathered to produce a listing of problem areas and unresolved issues, as well as interim strategies for dealing with the problems. Practical issues covered are: (1) importance of regular practice and problem of "drop-outs:" (2) choosing appropriate candidates: (3) potential adverse effects of meditation: (4) the meditating therapist: and (6) an attempt to specify the unique contributions of meditation to therapy. (Author)

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Issues In the Therapeutic Use of Meditation

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Issues In the Therapeutic Use of Meditation

Meditation is the name given to a class of techniques which have been shown to produce a state of decreased physiological arousal in which concentration is focused and alertness maintained. Research has demonstrated its value in decreasing anxiety, improving one's ability react adaptively to stressful situations, facilitating self-actualizion, and in treating drug abusers and psychiatric patients. From all indications, meditation is not only being sought after increasingly by the general public for purposes of self-improvement, but counselors and psychotherapists also seem to be using it ever more frequently in their practices. The use of meditation has been reported within the contexts of psychoanalytically oriented, behavioral, humanistic, and transpersonal therapies. While the claims of meditation proponents have been generally supported, the evidence is not conclusive, and the number of parameters explored to date is very small. Given the lack of information available to counselors and therapists wishing to add meditation to their therapeutic repertoire, it is important to make maximal use of the research, and especially the accumulated clinical, knowledge dealing with meditation. Thus, it is the purpose of this paper to bring together research data, clinical observations, impressions, and suggestions to yield a listing of problem areas and unresolved issues, as well as ways to deal with the problems so that meditation may be used clinically with the maximum benefit and minimum of harm.

Meditation must be practiced regularly to have an effect.

Clinicians have reported that clients may refuse to learn to meditate because it is incompatible with their l fe-style, because they fear loss of control, or they fear that their symptoms will no lcnger exert interpersonal control (Carrington & Ephron, 1975). Possibly an even greater problem than refusal to learn is failure to continue the practice. Williams, Francis, and Durham (1976) reported that after six months only 18% of their sample of transcendental meditators were still practicing regularly. Otis (in Glueck & Stroebel, 1975) believed that many people find it impossible to enjoy the benefits of meditation and cannot tolerate the relative freedom from discomfort. In a study of meditating psychiatric patients (Glueck & Stroebel, 1975) 32% of the group had stopped their practice at follow-up. Having contacts with the local TM center seemed to be a large factor in helping people continue in the practice, which they found beneficial. Two other postulated reasons for the discontinuation of meditation were the difficulty of fitting the practice into a busy routine and the distressing appearance of thoughts which were usually repressed. Although it is suspected that some clients will steadfastly refuse to learn, many fears could be eliminated by a knowledgable and sensitive therapist.

Increased availability of unconscious thoughts and feelings are commonly reported, but if too much emotional material is released during meditations this process may be therapeutically harnassed. First the frequency of meditation may be decreased to

once a day, three times a week, once a week, or whatever reduction is necessary. In this manner the therapist may control to some extent any exacerbation of symptoms and still facilitate a steady release of new material to work with in therapy. Another method which can be combined with the first, especially in cases where the release of affect is intense , is to have the client meditate just prior to the session so the therapist can immediately help the client integrate the experience. The practice of the Therapist and client meditating together during the session (Carrington, 1978; Sutich, 1973) can also be helpful.

Appropriate and inappropriate candidates. The general clinical concensus is that meditation is particularly indicated for the following types of disorders: anxiety states, depression, obsessive-compulsive disorders, psychosomatic conditions, fatigue states, sleep disorders, substance abuse, dependent, passive, and inadequate personalities, and existential problems (Benson, 1975; Carrington & Ephron, 1975; Deatherage, 1975; Goleman, 1971: and Maupin, 1962). Most of these same authors agree that psychotics or borderline psychotics are inappropriate candidates for meditation because they may be unable to tolerate the thoughts and images that appear and meditation may reinforce their retreat from reality. However, Glueck and Stroebel (1975) took exception to this exclusion of psychotics since they found that psychotic depressives and schizophrenics were able to learn and possibly benefit from the practice of meditation. They also reported that all but the most severely disturbed patients were able to learn TM with relatively little difficulty. Since their opinions are based on more

personal clinical experience than that of other writers, the previous suggestion that meditation should not be tried with psychotics is questioned, and more empirical data is awaited to settle this important issue. There is really no sound empirical basis at this time for selecting clients likely to respond favorably to meditation.

Another selection problem involves the choice of the specific meditation technique as a treatment for a particular client or type of problem. Several writers (Goleman, 1971; Naranjo & Ornstein, 1971) have addressed themselves to the possibility that the variety of meditative methods have specific effects which may have implications for therapy, but at this point no comparative studies of clinical effects have been performed. For example, it may be that concentration on the breathing, a common Zen method, may be inappropriate for hypochondriacs because this focusing could encourage the client to find additional somatic aberrations. This is a fruitful area for future research.

Meditation "casualties." There have been numerous reports of adverse reactions to meditation. Kennedy (1976) came in contact with two cases of depersonalization syndrome induced by self-taught meditation practices. Lazarus (1977) stated that, though meditation helps many people, there are indications that it can precipitate depression, agitation, and even schizophrenic decompensation when used indiscriminately. The occurrence of overt psychotic episodes has been verified in a few instances (Carrington & Ephron, 1975; Glueck & Stroebel, 1975) but usually in individuals with a previous psychiatric history and who did not follow the rules about the duration and frequency of meditation.

"Casualties" from meditation have usually been linked to "overmeditation" or practicing more than the prescribed amount (usually two 20-min periods per day, as in TM), which leads to a release of so much unconscious material that they are unable to assimilate it. It appears that while meditation may be used in some borderline or psychotic conditions, it's use should be carefully monitored and supervised; it's duration and/or frequency should be attenuated; and it should probably be done just prior to or during the counseling session so that the material may be utilized for therapeutic gain. The success that Glueck and Stroebel had with the psychotic patients may have been due to the daily supervision each patient received during the first weeks of meditation. With less disturbed individuals such close supervision may not be crucial, but a lack of follow-up monitoring may be one reason why the drop-out rate from the TM program is so high.

Meditation is not a panacea. Despite assertions that meditation is a meta-therapy and that it has far-reaching physiological and psychological effects, the simple fact is that it does not seem to help everyone who tries it. The various studies of the therapeutic effects of meditation in both clinical and normal populations do suggest beneficial results, but none reveal changes in all subjects, or relief in all clients. Probably very few therapists would believe any longer that a single treatment could help every person to whom it is applied, but a superficial look at the claims made for meditation could give one the impression that meditation is the universal cure. Meditation is clearly not a

panacea because not all patients want to learn it; the severely disturbed can't learn it; and not all those who learn it continue with it and benefit from it. The task of future work in this area is to identify the problems with which meditation will be the most beneficial and the most efficacious relationship between meditation and psychotherapy.

Should the therapist also meditate? The opinion of the several writers who have addressed this question is, "yes," the therapist who prescribes meditation should also be a meditator. (Carrington & Ephron, 1975; Deatherage, 1975; Goleman, 1971; Schuster, 1977; and Weide, 1973). In this way the therapist can better understand and help the client when he/she has problems in meditation. In addition some therpists have found it helpful to meditate with the client in psychotherapy under certain conditions. In general, a meditating therapist is felt to be able to communicate more effectively with the meditating client.

In a provocative study Lesh (1970) found that counseling students who were trained in TM increased significantly more in measured "empathy" than did a control group who were not interested in meditation. Though this study has important implications for therapists, the results are confounded because of self-selection into treatments and because the TM group was initially higher in empathy than the control group.

Is meditation unique in its ability to bring about the reported therapeutic benefits? One may ask whether meditation is

unique in offerring what it does and whether the same results can be achieved by other methods. Most of the ensuing considerations are speculative because very few researchers have compared meditation to other techniques capable of achieving the same goals.

Certainly there are other methods for producing relaxation, such as progressive relaxation, so meditation is not singular in this respect. However Wallace and Benson (1972) concluded that meditation produces a unique physiological state. Some aspects of meditation are said to be similar to systematic desensitization (Goleman, 1971) and behavioral self-control strategies (Shapiro & Zifferblatt, 1976). Meditation's ability to aid the release of repressed memories (Owens, 1975) has been compared to free association. The effects of meditation have been shown to be similar to those of psychotherapy by its success in decreasing neuroticism (Williams et al., 1976); improving scores on personality tests (Van den Berg et al., 1976); and increasing self-actualization (Hjelle, 1974). Meditation's alteration of stress responsivity (Goleman & Schwartz, 1976) may be a unique contribution.

The fact that meditation has some effects in common with all of these diverse techniques leads one to question the utility of the method since it may have few truly characteristic defining properties. However, when one views meditation as possibly capable in itself of producing, or as assisting other methods (e.g., psychotherapy), in producing all of the effects mentioned above and perhaps others not yet investigated, then meditation comes to appear quite singular in having a <u>constellation</u> of therapeutic

effects. The promise of a technique with such potentially broad impact, combined with the fact that it is easily learned and practiced, suggest that intensive investigation is needed to further verify the preliminary findings; define its contributions to therapy; explore its basic processes; and demarcate its limitations and attendant dangers. The present state of the literature is incomplete, but based on available studies and reports from clinicians, it appears that meditation, by itself, is not a valid therapy because of the dangers which can result from misuse or lack of supervision, but in the hands of a knowledgeable and competent therapist, meditation may be quite a valuable therapeutic adjunct.

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